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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Strangulated Hernia. By JOHN W. HULKE, F.R.S. Delivered at Middlesex Hospital.

GENTLEMEN: No accidents are more deserving of your closest attention than strangulated ruptures, for it is scarcely an exaggeration to say that no two are alike in all their circumstances, and upon your prompt appreciation of these will mainly depend your patients' rescue from a condition which, when unrelieved by art, is so desperate, so nearly hopeless, that it well deserved the name our forefathers gave it—a "*miserere.*" There have been lately in Broderipp ward two cases which it will not be unprofitable for us now to review.

The first is that of a muscular, healthy carpenter, aged 27, who was admitted into Broderipp ward at 4 A. M., October 14, 1873. The right side of his scrotum was distended by a very large, extremely tense, globular swelling, which below concealed the testis, and above was continuous with an oblong portion in the inguinal canal. When he coughed, no impulse was communicated from the belly to the scrotal tumour. It and the belly were very tender, and so painful that he writhed restlessly about in bed and begged for something to be done speedily to relieve his suffering. He frequently retched. His face was pale, and its expression anxious. His pulse was quick and small.

He had had a rupture for many years; it had sometimes come down, and until now he had always managed to replace it.

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Latterly he had worn a truss. The rupture had slipped down at midnight; he could not get it back; it directly became extremely painful. He began soon after to vomit, and felt very ill.

At five o'clock, when I saw him, he was at once placed under the influence of chloroform, and, when complete relaxation was obtained, the taxis was tried for a few minutes. Not being successful, without further loss of time the hernia was operated on under a carbolized spray. A cut, about three inches long, was made in the long axis of the tumour, with its centre over the depression which marked off the scrotal swelling from that in the groin. When the external inguinal ring, where the seat of the strangulation was expected to be, had been notched, and some tight threads of fascia transversalis upon the outer surface of the sac had been cut, another attempt was made to reduce the contents. It failed, and the sac, which was very thin and transparent, was opened. A coil of dark purple intestine came clearly into view. The finger could be passed upwards through the internal ring without meeting any obstacle, yet still reduction was impracticable. The impediment now appeared to be in the scrotum; and on passing the finger downwards, at about one inch from the lower angle of the wound, a sort of transverse diaphragm was found dividing the scrotal part of the sac into an upper and a lower compartment, which communicated by a small circular aperture. When this had been notched, and a recent adhesion of the gut just above it had been separated, several coils of small intestine, almost black, and spotted with many small hemorrhages, were easily drawn out of the lower compartment and reduced. They were lying upon the testis. The wound was washed out with a watery solution of 1 per cent. of carbolic acid, closed with wire stitches, and dressed antiseptically. He was ordered one grain of opium at intervals, the length of which was to depend on pain. The wound healed almost wholly at once; a very slight inodorous, sero-purulent discharge oozed for a few days from the upper angle. The bowels first acted on the 21st, and until then he was restricted to a milk diet. At the end of the month he was convalescent.

The next case is that of a large, heavy brewer's drayman, aged 23, also lately in Broderipp ward. He had had a rupture since childhood, but he had never worn a truss. At long intervals the rupture had occasionally slipped down, but until now it had always been reducible. At 4 P. M. whilst hurrying to catch a train, he felt it pass into the scrotum; and he was directly seized with great pain followed by sickness. His attempts to reduce the rupture failing, and his suffering becoming very great, at 7 P. M. he was brought to the hospital. When I saw him (four hours after the accident) the right side of his scrotum was distended by a very tense rupture, about a span long, separated by a shallow groove at the external abdominal ring from an upper portion filling the inguinal canal. The scrotal part did not receive any impulse from the belly when he coughed. The testis could be plainly felt at the bottom of the scrotum, distinct from the rupture behind it. He was bent double with pain in the belly and rupture —the latter, too, was so tender that he could not bear it to be handled; and he was sick. We at once gave him chloroform, then tried the taxis for a few minutes, and, not succeeding by it, operated.

When the external ring, where the strangulation was expected, had been notched, an attempt was again made to reduce the contents without opening the sac, but this could not be effected. The sac, as thin as tissue-paper and quite transparent, was then opened. It contained a large piece of omentum slightly congested, and behind this several coils of dark-purple small intestine. The obstacle to reduction was found to be a couple of tight fascial threads crossing the neck of the sac and blended with it; after their division the intestine and omentum were returned without difficulty. The sac also contained about two ounces of bloody serum. Antiseptic precautions were taken during the operation, and the wound was dressed antiseptically. It healed almost entirely at once; there was a slight suppuration only in one suture-track. The

first stool was not passed until the fourteenth day, when, the belly being rather uneasy, a simple enema was given, which brought away many scybalæ. About a week later, when quite convalescent, he had looseness, with tenesmus, caused by impaction of feces in the rectum. It ceased on their removal, and a couple of days afterwards he returned to work.

These, gentlemen, are pattern cases of large, acutely strangulated ruptures in young muscular subjects. In the first patient recourse was had to herniotomy five hours, in the second four hours, after the accident. To some of you this will perhaps have appeared a hasty proceeding, and you would like to ask me why we did not give the taxis a longer trial and put the patient into a hot bath; why the effect of a full dose of opium and of ice upon the rupture was not tried before operating—measures which you have known successful in other cases. The reply is, that when unsuccessful these measures have entailed a loss of time which in acute cases is very perilous; and here the ruptures were so tense, presumably therefore the strangulation so tight, that the chance of their succeeding was almost *nil*. It is in the less acute strangulations, where a few hours' delay in operating does not much increase the danger, that they find their proper place. Experience has only strengthened my conviction that abuse of the taxis has contributed in no small degree to swell the mortality after operations on strangulated ruptures. I speak not merely of a misplaced confidence in it, by which precious time is lost, during which the patient's condition drifts into constantly increased dangers, but of injuries inflicted by the use of force unwarrantable in degree and faulty in direction. Two cases which I watched with intense interest made a lasting impression on my mind. I will briefly relate them as warnings to you.

A young widow, ruptured four years, wearing a badly-fitting truss, had her rupture slip down and become strangulated. For three days her medical attendant assiduously persevered with the taxis. At last she was brought into a hospital. In her right groin was a large, tense, tender crural rupture. She complained of a dreadful screwing pain in the belly at the navel, and of great thirst, and she vomited a pale coffee-coloured, fecal-smelling fluid. The house-surgeon put her into a hot bath and repeated the taxis, with the result that the contents of the rupture suddenly slipped up into the belly. She instantly cried out with excruciating pain above the pubis, she exclaimed that she thought her bladder had burst. Two hours later the pain was, if possible, still more intense, and her suffering was heightened by a sensation of distension, as if her belly were about to burst. Her face was pale, her features pinched and sunken; her pulse small, intermittent, weak, and so rapid that it could hardly be counted; and she retched, with little intermission, bile-coloured matters.

The sudden way in which the contents of the rupture went up into the belly, raised the suspicion that possibly they might have slipped up through the crural opening still inclosed in the sac, and constricted by its neck (reduction *en bloc* or *en masse* as it was named by Claquet). It was ascertained by an exploratory operation that this mishap had not occurred. She died seventeen hours after the reduction of the rupture.

At the examination of her body the sac and the tissues around it were found in a nearly gangrenous condition. Six inches of the ileum were gangrenous, and in this part was a small hole through which feces had run out into the peritoneal cavity. The pelvis contained about a pint and a half of a turbid, yellow, feculent-smelling serum, and there were evidences of an intense general peritonitis. Had this woman's rupture been operated on early instead of being repeatedly submitted to the taxis, she would probably have recovered; and even on the fourth day—by which time its contents had become gangrenous—had the taxis not been repeated, but herniotomy been done, and the sac opened, the gangrenous condition of the strangulated intestine would have been ascertained, a safe outlet for its contents might have been made, and recovery with an artificial anus been still possible. As it was, misuse of the taxis allowed the

gut to become gangrenous, then burst it, and killed her.

Several years later I witnessed another case where I could not resist the conviction that the patient's death was directly due to violent manipulation. The rupture was umbilical, very large, of several years' formation, during which the patient, a stout middle-aged woman, had been plagued with dragging pains, and with retching, which were relieved by simple domestic measures. At last strangulation occurred, and her condition growing desperate, additional advice was obtained. Happening to go in, I saw the surgeon standing upon a stool, bent over his patient, energetically kneading the rupture with, as it seemed to me, a dangerous expenditure of force. She suddenly swooned, and in a few moments life was extinct. At the examination of her body, her stomach, much dilated and thinned, and partly drawn into the rupture and entangled in it by adherent omentum, was found burst; the rent was extensive, and the contents were diffused through the peritoneal cavity.

I have, also, several times found the skin red and ecchymosed, and the superficial cellular tissue so much more congested than that nearer the sac, that I felt constrained to refer these disorders to external injuries, and not to any spread of inflammation from the rupture to the surface. The lesson which cases such as these and the two I have just related convey is that any handling of a strangulated rupture should be very gentle. The only justifiable taxis is a gentle, uniform, steady compression, combined with an equally gentle pushing in the direction of the channel through which the viscera have protruded from the belly. This, whilst far safer, is also much more efficient than the forcible jerky squeezing occasionally witnessed.

To return to our two cases. You will have remarked that they have several common features and one notable difference. Both patients were young muscular men; in both the local and also what are termed the "general" or "constitutional" symptoms were urgent; the nervous commotion, pain in belly, and sickness were great, and the morbid changes in the strangulated viscera were already very considerable, although so short a time as only four hours in one and five hours in the other case had elapsed. In the first rupture the intestine in the sac was even more excessively congested than in the second. Two circumstances conduced to this—first, the contraction of the inguinal ring consequent on the recent use of a truss; and next, the existence of a double strangulation, one at the external abdominal ring, the other in the sac occasioned by the sharp edge of the circular partition which divided this into an upper and a lower compartment. You will recollect that the intestine in this compartment was even more congested and more spotted with extravasated blood than that in the upper space between this partition and the external ring. You will also have noticed that the intestine was directly in contact with the pelvis—in short, that the hernial sac was the tunica vaginalis testis (the obscuration of the testis by the rupture raised the suspicion of this before the operation)—the characteristic of the variety of rupture named "congenital," because conditioned by the persistent openness of the tube of peritoneum, which the testis draws after it in its passage from the loins into the scrotum, in the eighth month of fœtal life, and which, soon after the testis has left the external ring, normally begins to be obliterated and converted into a solid fibrous band.

The partitions in the upper part of the sac, so frequent in congenital hernia (I have several times met with one, and more than once found two), probably have their origin in incomplete obliterations of this peritoneal tube. Their presence is an additional complication, and it may, perhaps, partly explain the much greater danger of strangulated congenital ruptures than of herniæ acquisitæ of similar bulk and at the same time of life—a circumstance so pointedly mentioned by Dieffenbach in his *Operative Chirurgie*, a book I cannot too strongly recommend you to read.

In our second case the hernial sac was distinct. Formerly this would have been regarded as a *hernia acquisita*—one whose

sac was a new bag of peritoneum pushed before them by the protruding viscera; but the early age at which the rupture first appeared, renders it very probable that it was really only a sub-variety of congenital hernia, in which the congenital peritoneal tube had been obliterated only just above the testis, so separating its dilated testicular part (now the tunica vaginalis) from the tubular part above, which remaining unclosed admitted the intestine into it, and became its sac. In connection with this, I would refer you to Mr. Birkett's article on hernia in Holmes's *System of Surgery*. The progress of both cases after the operation was all that could be desired. The symptoms of strangulation at once ceased, and those who saw only the calmness of the following day could scarcely realize the critical state which had so shortly preceded it. There was very slight febrile disturbance, and the wound healed almost wholly by first intention. How far this should be ascribed to the antiseptic precautions I cannot say, but I would lay great stress here, as everywhere in surgical operations, on the necessity of absolute cleanliness. To both patients opium was given, not in fixed doses and at stated times, but in quantity from half a grain to a grain, and at intervals entirely dependent on the existence and the degree of pain. This, which has been my practice many years, has afforded me very satisfactory results; it tranquillizes, and it keeps the bowels quiet. In one of our two cases no stool was passed until a week, in the other till a fortnight had passed. This did not occasion us any anxiety, and the only inconvenience resulting from the prolonged inactivity of the bowels was a slight impaction of accumulated feces in the rectum —an affair of very small importance. Do not take my remarks as a sanction to give opium necessarily in all cases; this would be a blamable want of discrimination. To some patients you will not need to give a single grain; to others you must give it boldly, but with judgment.—*Med. Times and Gazette*, April 4, 1874.

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Abstract of a Lecture on Puerperal Eclampsia, delivered at the Hôpital Saint Antoine, Paris, by M. Péter.—Puerperal eclampsia is one of the most important affections in obstetric pathology, and has always been a subject giving rise to endless controversies and experiments, mostly from the etiological, pathogenetic, and natural points of view. M. Péter, whose post at the St. Antoine Hospital allows him exceptional opportunities for studying this disease, has given two most interesting lectures upon it, of which we present the following summary. In the course of his lectures M. Péter strongly recommends the perusal of the excellent article by M. Bailly, in the lately published *Dictionnaire de Médecine et de Chirurgie Pratiques*, to which he renders a just meed of praise. It is constantly advanced as a fact that all pregnant and eclamptic women are albuminuric; that the albumen may disappear for some hours, and that eclampsia in pregnant women without the presence of albumen forms a very rare exception. Thus there may have been recorded six or seven cases of eclampsia without albuminuria.

Two questions immediately arise. The first is what is the reason of this frequency? To this the reply is, that there is a larger mass of blood in circulation. The second is, as to whether cases of eclampsia have become more common during the last thirty years. To this the evidence of statistics gives an affirmative reply. The hypertrophy of the heart during pregnancy shows the increased amount of blood in circulation. The demands of the uterus are augmented, and the blood of the mother has to supply the nutrition of the fœtus. Therefore the maternal organism ought to benefit by this larger volume of blood; and, as a matter of fact, the woman does present both the appearance and the reality of plumpness. This fact being established, what then are the accidents which are likely to occur in such a contingency, the organs liable to be affected being the lungs, liver, and kidneys?

With regard to the lungs; as the mother is obliged to make blood for two, we find pulmonary oppression, and when this symptom is increased, hæmoptysis. If the heart be diseased, with presumable

mitral insufficiency, we meet with double pulmonary congestion. These facts declare themselves, and these accidents appear towards the fifth month of pregnancy. With regard to the liver, we generally find simple icterus; acute icterus is uncommon.

We now proceed to consider the accidents to which the kidneys are liable during the pregnant state. In the same way as the mother makes blood for two, so she makes urine for two. The analyses of the urine and its elements demonstrate that there is a larger quantity of urea in the pregnant woman; and M. Quinquaud has found that, instead of 22 to 24 grammes in the twenty-four hours, she eliminates 30 to 38 grammes of this substance. A larger quantity of blood implies greater pressure, and consequently more filtration, when not only albuminuria, but discharge of serum with the urine occurs.

According to the writings of Charles Bernard and the negative deductions he has drawn from his experiments, urea is not the cause of eclampsia, any more than is carbonate of ammonia. Neither is it uræmia, nor ammoniæmia, nor creatinæmia; but, according to M. Péter, creatinæmia. M. Quinquaud, who has made three analyses, found, instead of 6 parts of extractive matters, 21 per cent. in the first, 19.2 per cent. in the second, and 18.3 per cent. in the third.

The frequency of puerperal urinæmia has been increasing, a fact proved by M. Charpentier's inaugural thesis, in which he gives the following statements compiled from the records of the Hopital des Cliniques during thirty-eight years: From 1834 to 1843, seventeen cases; for 1844 to 1853, twenty-seven cases; from 1854 to 1863, thirty-five cases; from 1864 to 1871, fifty-four cases.

MM. Andral, Gavarret, Becquerel, Rodier, and Reynauld have demonstrated that pregnant women have fewer red corpuscles, whence it has been concluded that all pregnant women are anæmic. M. Reynauld has analyzed the blood of thirty-four pregnant women; the normal state of the blood-corpuscles is 127 per 1000, but this observer counted 145 in one instance, 127 in another, from 125 to 120 in six cases, and from 120 to 195 in twenty-six. Thus it is evident that one-fourth escaped anæmia; besides which, before having arrived at that conclusion, it would have been necessary to analyze the blood of those women before they had reached their physiological state for the time being, in view of the anæmia possible before, during, and after pregnancy. The anæmia of pregnant women does not rest on any logical interpretation, and tocologists commit a *petitio principii* when they refer pulmonary oppression, spitting of blood, and albuminuria to anæmia, by referring the eclampsia of pregnant women to anæmia of the bulb. This affection has also been termed serous plethora, a term to which we give our adhesion; but then the patient has serous blood; that is to say, blood less rich in corpuscles, giving rise to congestions of the liver and kidneys, which leads to icterus, voiding of serum, etc. If the bile were secreted by a gravidly congested liver, M. Péter believes that we should find in it serum, leucocytes, and blood-corpuscles.

The question is briefly as follows. Must we prevent congestion in the region of the kidneys? To answer this question, we must divide it into two branches: 1. How to foresee the accidents; 2. How to prevent them. For the first object, M. Péter recommends that the urine of all pregnant women should be examined. If, on the one hand, he note the presence of serum towards the fifth month, and, on the other, symptoms of cephalalgia, he is on his guard. The headache is very painful; it is seated in the anterior portion of the cranium, rarely in the occiput; at first it is fugitive, only appearing at certain times, and subsequently becomes persistent. "Unhappy is the patient," says M. Péter, "in whom this symptom becomes persistent."

After headache, visual troubles come on, troubles which consist in a difficulty of grasping the outlines of objects. The patient is unable to read for many minutes at a time, and she vomits if she wish to continue reading. She sees coloured spots (irisation) in consequence of want of accommodation, and may subsequently

be affected by amblyopia, hemiopia, or amaurosis, going on to total blindness—a stage when the attack of eclampsia is not far off. The ophthalmoscope gives no indication; the transparent media are intact, and there is nothing in the retina. The hyperæmiæ, which cause these functional troubles, occur in the cerebral centres. M. Bailly has observed a little suffusion in the conjunctiva, especially at the level of the oculo-palpebral folds, a kind of serous chemosis.

There are other prodromata equally conclusive with those already enumerated, one of them being a feeling of oppression at the epigastrium, as if there were continuous pressure on the epigastric cavity. This may probably be a species of aura seated in the pneumogastric nerve, a view of the case warranted, in M. Péter's opinion, by that other important and significant phenomenon, dyspnœa. Vomiting forms another highly important symptom. The attacks are frequent, and the matter ejected consists of stomachic mucosities, bile, and food, when the sickness comes on after a meal. Finally, vertigo, dulness of the intellect, insomnia, or comatose sleep and restlessness, are observed.

Having thus enumerated the prodromata of the eclamptic attacks, M. Péter proceeds to consider the causes of urinæmia, which have been classified as: 1. The compression of the inferior vena cava and the renal vena by the gravid uterus; 2. Double pregnancy; 3. Triple pregnancy; 4. Rickets. These eclamptic attacks mostly come on from the fifth to the ninth month, and especially in the ninth month.

On this point M. Péter's conclusion is, that the congestion is in direct relation to the quantity of blood in circulation, and the quantity of blood is in direct relation to the double or triple alimentation which the maternal organism is obliged to bear, and which it must supply. The greater the functional need the greater the purificative need; whence arises a functional hyperæmia in proportional relation to the needs of two or three organisms. M. Péter, taking heed of the most salient facts, recommends bloodletting as a preventive measure, which is also advised by Cazeaux and Beau. The latter only takes away 60, 90, or at the most 120 grammes; M. Péter makes his minimum quantity 150 grammes, with the addition of the removal of blood by cupping in the region of the kidneys.

Bloodletting is also extolled as a curative measure by M. Péter, MM. Depaul, Dubois, and Cazeax; it does not always cure, but it is sure to give immediate relief. In reference to this practice, Holz wrote to M. Charpentier that "of all the means employed, bleeding has proved the least unreliable."

A second method is to give emetics in contra-stimulating doses (*doses raisorienes*). The third plan is the use of anæsthetics, particularly chloroform, a plan which has its partisans, its neutrals, and its enemies; that is to say, it has been powerful in the hands of the first-mentioned, useless with the second, and mortal when employed by the last. As surgical treatment M. Péter recommends artificially induced accouchement, especially where the medical treatment has failed.

Eclampsia is a most serious affection. A great proportion of the sufferers from it die, and if they recover the cure is not complete, and Bright's disease is a certain result. Amongst all the accidents to be dreaded as likely to carry off the patients, one of the most serious is uterine hemorrhage, a result of the typhization of the blood, an accident first observed by Blot, and which cannot be arrested by any expedient whatsoever.—*London Medical Record*, April 1, 1874.

HOSPITAL NOTES AND GLEANINGS.

Neuralgia treated by Phosphorus.—Dr. Bradbury has in the out-patient department of Addenbrooke's Hospital, Cambridge, been lately testing the value of phosphorus in neuralgia. On the whole, he has met with considerable success from its administration. The following are two cases in which the drug effected a cure when other remedies had failed.

Case I.—E. P., aged 24, single, shopwoman, living in Cambridge, was first seen on October 29th, 1873. She had

suffered from trigeminal neuralgia of the left side for three months. As the bowels were confined, and she was somewhat anæmic and the catamenia scanty, a draught containing one grain each of sulphate of iron and sulphate of quinia, five minims of dilute sulphuric acid, and half a drachm of sulphate of magnesia, in an ounce of peppermint-water, was ordered thrice daily. She persevered with this mixture till December 22d, with only slight improvement. On this day the pain was very severe, and she was ordered a phosphorus capsule (= one-thirtieth of a grain of phosphorus), to be taken twice daily after food. After taking two capsules, the pain entirely ceased; and on January 12th, 1874, the patient was discharged quite well, having had no recurrence of the neuralgia.

Case II.—E. H., aged 40, married, and living at Haslingfield, first came as out-patient on November 26th, 1873. For eight weeks she had had very severe trigeminal neuralgia, her features being expressive of great suffering. She was suckling her baby, although the child was fifteen months old. She was directed to wean the baby, and to take a mixture containing two grains of quinia and fifteen minims of tincture of sesquichloride of iron in an ounce of water twice daily. On December 6th, there was no improvement. As cases of ague had been admitted from this locality, Dr. Bradbury thought it possible the neuralgia might be of a malarious character, and ordered a mixture containing five minims of solution of arseniate of soda, one drachm of tincture of hop, and half an ounce of water, to be taken thrice daily, with the meals. A chloroform and belladonna liniment was also prescribed to be applied to the painful part. When next seen (December 20th), she was as bad as ever, so a phosphorus capsule was prescribed, to be taken thrice daily after food. The patient was also ordered to rub into the temple every night a little aconitine ointment. The relief from this treatment was most marked; and when the patient was last seen, on January 31st, 1874, there had been no recurrence of the pain for more than a month.—*Brit. Med. Journal.*, March 14, 1874.

Rheumatism of the Tendons.—Under the care of Dr. PETER at Hôpital St Antoine, Paris. The patient, aged thirty-five, had been suffering for a few days from pain in the situation of the joints of the knees and ankles. No swelling or redness was to be observed in the painful situations; no general symptoms of rheumatism; no fever. The pain was developed when the finger was moved carefully along the head of the fibula, on the tibia in the situation of the aponeurotic expansion of the tendons, and behind the malleoli. Movements of the articulations were painful through the straining exerted on the inflamed tendons.

M. Peter has often observed such cases of rheumatic inflammation of the tendons and serous bursæ, unconnected with gonorrhœa. The pain is to be sought after, not with the hand, but with the finger, carefully exerting pressure on the situation of the tendons and bursæ—for example, behind the ankles, between the biceps and head of the fibula, above the aponeurotic expansion of the knee, behind the calcaneum and the olecranon, in front of the patella, in the situation of the great trochanter, etc. The disease is really an extenuated form of rheumatism, and constitutes rheumatic synovitis. It rarely presents cardiac complications. It is seldom accompanied by any great fever, though sometimes the fever may be somewhat high, and the evening temperature may rise to 39° or 40° Cent. There may be slight œdema or not in the situation of the inflamed tendons. Likewise the surface may be discoloured or not. It is much milder than articular rheumatism, and does not require any energetic treatment.—*Lancet*, March 28, 1874.

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Hemorrhagic Smallpox.—Dr. A. EWALD, of Charité, Berlin, reports (*Irish Hos. Gaz.*, April 15, 1874) the following case:—

On Feb. 26, a young man, aged 21, who gave the following history, was brought into the Clinique of Prof. Frerichs. On the morning of the preceding day he had been attacked with slight pain in the head and back, which did not, however, prevent him from following his busi-

ness as a painter. Gradually the pains became more severe, and there appeared small, isolated, red spots on his chest and abdomen. The number of these spots increased most rapidly during the night. He was then attacked with great weakness and lassitude, and, when admitted, was no longer able to walk or stand; he had had no palpitation of the heart, no cough nor pain in the throat; till the day before his admission he had always been healthy.

On examining the patient, who was a strong-built, well-developed man, though at the time in a state of great prostration, what at once riveted the attention was a copious purpura-like eruption, the hemorrhagic spots forming which were about the size of split-peas, and of a brown or bluish-red colour; they were most numerous in the hypochondriac region and about the groins, in which situations they coalesced and formed islands of bluish-red ecchymosis. They were much less numerous along the inner side of the extremities, though somewhat more plentiful in the neighbourhood of the joints, and there were few on their outer surface; the face remained quite free. Both the ocular and palpebral conjunctivæ were, however, bulged forward by a reddish-brown infiltration, looking like chemosis. All the spots were true hemorrhages, and nowhere was there the slightest elevation of the cuticle, or the least attempt at the formation of a pustule or vesicle, except on the dorsum of the right foot, where there was a vesicle about the size of a split-pea, which was filled with an opaque whitish fluid; the centre of this vesicle was not, however, in the least depressed. There was slight hemorrhage from the gums, but a cursory glance at the interior of the mouth and fauces detected nothing abnormal. An examination of the internal organs failed also to discover any structural changes. The heart sounds were healthy, the pulse of average fulness and compressibility, and there was no elevation of temperature. The treatment consisted in the administration of large doses of ergot, and some wine, with a cold compress over the eyes. In spite of these measures, however, the symptoms of debility gradually increased, and the patient was dead within two hours.

We were greatly helped, in forming our diagnosis of this case, by being able to exclude two diseases, the symptoms of which are very similar to those just described, viz., scorbutus, and endocarditis with numerous embolisms in the skin (the rapid course of the disease contra-indicating them both, the absence of all heart symptoms more especially the latter). There only remained, therefore, for our consideration, the large group of acute exanthemata, in severe cases of which, as is well known, similar hemorrhages have been observed during the period of invasion. If the symptoms, and more especially the pustule on the dorsum of the foot, made it very probable that the case was one of variola hemorrhagica, this probability became a certainty when, some hours afterwards, a patient, with similar hemorrhagic spots, but with typical smallpox eruption, was brought into the hospital from the same house as the former. This latter patient was at once transferred to the smallpox ward.

The *post-mortem* appearances found in the former case confirmed, as far as they went, our diagnosis. There were numerous extravasations of blood found in the cellular tissue between the muscles, as also in the serous envelope of the internal organs (pericardium, pleura, etc. etc.), but none in the parenchyma of the organs themselves, except in the testicle, in the substance of which gland there were found two extravasations about the size of peas.

The appearances found under the microscope showed that the extravasations had taken place immediately beneath the surface of the true skin, and had penetrated it to a distance of three millimetres, the epithelial layer being continuous over them. The blood corpuscles were especially numerous around the vessels of the papillæ, the hair bulbs and the sweat-glands not being involved.[1]

[1] This quite agrees with the description given by Wagner in the *Archiv für Heilkunde*, 1868, and that given afterwards by Wyss in the *Archiv für Dermatologie*, 1871. The view taken by the latter, from the great number of

The above cases are made more interesting from the fact that there have not since been any more similar ones. For it is most rare for cases of variola hemorrhagica to be met with, except during or immediately preceding an epidemic, and they occur very seldom without powerful predisposing circumstances. Prof. F. Meyer, who has had great opportunities for observation, has been kind enough to inform me that he has had similar cases among the best families. These cases, which correspond accurately to the description above given, always prove rapidly fatal. The most striking symptom is the enormous and rapidly-spreading hemorrhage, along with which we usually, though by no means invariably, find one or more pustules, with leaden-coloured contents, usually seated on one or other extremity. In no case that has been observed up to the present has, however, death followed so rapidly as in this, which is on this account one of peculiar interest.

I have since heard that the second patient who was transferred to the smallpox wards, and thus withdrawn from my care, is also dead.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Bromide of Potassium in Dental Irritation.—Dr. J. Lewis Smith states (*Medical Record*, May 1, 1874) that bromide of potassium in cases of dental irritation in infancy is so salutary in its effects, that the gum-lancet need scarcely ever be resorted to. It should be administered in doses proportionate to the age of the child, and repeated according to circumstances. The remedy is of service in the treatment of all local diseases except gastro-intestinal irritation and renal disease, where convulsions are threatening.

Inhalation of a Bead; Tracheotomy.—Dr. Sayre exhibited to the New York Pathological Society a small oblong bead, tapering at each end, which he had removed by tracheotomy from a child aged six years who had been brought to him by Dr. Cleary, of Gloucester, New Jersey. The child had accidentally inhaled the bead five days before, and when seen by Dr. Sayre presented an exceedingly anxious expression of countenance, had a constant irritative cough, and complained a great deal of pain in the chest under the sternum. The respiration was somewhat noisy, and the foreign body could be heard like a weaver's shuttle, as it struck against the glottis. Judging from the size of the bead, a companion to which was shown at the time, Dr. Sayre concluded to perform tracheotomy for its extraction. The patient was etherized and the operation done in the usual manner, assisted by his son, Dr. Crosby, and Dr. Yale. The instant the trachea was opened, the bead was coughed out, when the patient took a deep inspiration and was apparently dead. Artificial respiration was kept up for thirteen minutes before the diaphragm would act of its own accord, and then occasionally for half an hour more. A galvanic battery was for most of the time brought in requisition. Finally a piece of inspissated mucus was coughed up, which, having a cavity in its centre corresponding to the size of the bead, was evidently its envelope, or, as Dr. Sayre expressed it, its "overcoat." He supposed that the bead, at the moment it was projected from the trachea, lost its "overcoat," which covering at the first inspiration afterwards was drawn into the trachea down to the bifurcation, completely arresting the ingress of air.

Another interesting fact connected with this case was the ease with which the respiration was kept up, and for such a length of time, through the artificial opening.—*Medical Record*, April 15, 1874.

Nasal Polypus.—Dr. Keyes exhibited to the New York Pathological Society (*Medical Record*, April 15, 1874) a young man upon whom he had operated for the extraction of a nasal polypus (myxoma). The growth commenced, seven years before, in the right nostril, and continued to

the blood-extravasations, that it is not so much a question of rupture of the coats of the vessels as of diapedesis, or escape of the blood corpuscles through the walls of the vessels, similar to that observed in inflammation, is probably true of the above case also.

increase gradually for four years, at the end of which time it was extracted by means of the polypus forceps. No relief followed; and the tumour, which evidently had not been extracted entire, continued to increase, and three weeks ago the patient consulted Dr. Keyes. The right nostril was then entirely occluded, and there was considerable deformity on the external aspect of the nose. An attempt was made to find the pedicle by the use of a probe, but without success. It seemed to be high up, and very long. Extraction with the long forceps was done, and as much of the tumour as could be reached was torn away. No relief followed. It was then discovered that a large remaining portion of the tumour was situated in the posterior nares. The patient being etherized, the forefinger of the left hand was introduced its whole length into the right nostril, which was unusually small and very dilatable. The forefinger of the right hand was then introduced into the mouth; the tumour, which was already well pushed back, was easily hooked backwards, and removed entire. The attachment was found high up on left side. The polypus itself contained in its substance two cavities of pus.

The interest of the case consisted in the felicitous method of operating, and in the apparent *à priori* impossibility of introducing a moderately large finger with such ease into a very small nostril.

In reply to a question from Dr. Knapp, as to whether the method of operating was original, he remarked that he had obtained the idea from Prof. Frank Hamilton, who had been accustomed to employ a similar procedure in such cases.

Dr. Sell remarked that Prof. Billroth performs the same kind of operation.

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Villate's Mixture in Chronic Otorrhœa.—Dr. R. R. Hopkins states (*N. O. Med. and Surg. Journ.*, May, 1874) that he has used Villate's mixture, as recommended by Dr. Poulaillon, in four cases of chronic otorrhœa, with success. The formula for that preparation, with the views of some French surgeons as to its value in caries, fistulæ, and abscesses, will be found in the number of the *Med. News* for July 1866, p. 114.

Administration of Bromide of Potassium.—Dr. Squibb, at a recent meeting of the New York Academy of Medicine, stated (*Medical Record*, May 1, 1874) that he always employs a watery solution of bromide of potassium of the strength of 12½ grains to the fluidrachm. The solution is always filtered, for by this precaution a solution which will remain clear is obtained.

The best vehicle for the administration of the remedy is ice-cold water. He has not found any stomach which has rejected the remedy when given in this manner. It is not well to administer it too near the digestive process. It should not be administered nearer than fifteen minutes before a meal. If given immediately before a meal, there will probably be developed evidences of interference with digestion. This is a rule which, for obvious reasons, it is well to observe, with regard to the administration of any of the alkaline salts.

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Cancerous Liver.—Dr. R. P. Hugen, Assist. Phys. Alabama Insane Hospital, reports (*Charleston Med. Journ.*, April, 1874) a case of hepatic cancer in which the liver attained the enormous weight of 15 lbs. 10½ oz. (avoir.).

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Virginia Medical Monthly.—This is the title of a new journal, of which the first two numbers have been issued. It is edited by Landon B. Edwards, M D., and the present numbers are well supplied with interesting matter.

FOREIGN INTELLIGENCE.

Antalgic Properties of Essence of Mint.—Dr. Delioux de Savignac announces (*L'Union Médicale*, 21 April, 1874) that the essence of mint applied externally to a part affected with neuralgia will completely relieve the pain. The Chinese made this discovery years, perhaps centuries, ago. (See No. of this Journal for Jan. 1871, p. 14.) We have repeatedly used the oil of peppermint, applied locally, for neuralgic and rheumatic pains and for migraine, and found it to be an excellent anæsthetic, affording often prompt relief.

Treatment of Diabetes.—In a paper recently published (*Sitzungsberichte der Kais. Akad. d. Wiss. zu Wein*, Bd. lxvi. Heft iii. iv. and v.), Dr. KRATSCHMER gives the results of a series of observations he has made on a diabetic patient, with a view of testing the value of carbonate and sulphate of soda, and of morphia, upon the excretion of sugar. He finds that neither the carbonate nor the sulphate appeared to exert any influence on the amount of sugar excreted, but he has satisfied himself that in morphia we possess an agent that is not only capable of materially reducing the excretion of sugar, but also of diminishing to a remarkable extent the general tissue metamorphosis of the body.—*Practitioner*, April, 1874.

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Chloral Hydrate successfully used in Tetanus.—Dr. CORYLLOS, of Patras in Greece, published a case of this kind in the *Allgem. Wiener Med. Zeit.*, No. 2, 1873, and now the same author records two similar cases, one under his own care, and the other treated by Dr. Basilin. The latter case relates to a woman of forty, who had wounded her finger with a splinter, which she removed herself. Tetanus occurred one month after the accident, and she had more than ten general attacks in the twenty-four hours. Sixteen days after the first tetanic symptoms the patient removed from the wound a bit of splinter, the size of a pea, which had been left in it unobserved. The usual narcotics having failed, chloral was tried and succeeded. Altogether three ounces and a half were taken in twenty days.

In Dr. Corylios' case a man of forty had his left temple wounded by a pointed piece of reed. Tetanus supervened, and here again, a portion of the foreign body was removed twelve days after the accident. He had at first fifteen-grain doses of chloral, and improved much upon them, but the tetanus recurred with renewed severity, and the chloral was pushed as far as 120 grains per diem. The patient completely recovered, and had taken, in about thirty days, six ounces of chloral. —*Lancet*, April 4, 1874.

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Treatment of Syphilis.—Mr. JONATHAN HUTCHINSON, in an article in a recent number of the *British Med. Journal* (Feb. 28, 1874), states that the object of his recent paper (see *Amer. Journ. of Med. Sci.*, April, 1874, p. 536) was rather to attract attention to the evidence in favour of the permanent efficacy of the mercurial treatment of syphilis in its early stages, than to advocate any special mode of its use. I was, however, led, he says, almost necessarily, in order to sustain my argument, to insist on the necessity for a long course, and, as a means in order to the practicability of long administration, on the avoidance of doses likely to cause salivation. I had to contend also that the antidotal power of the drug is in no degree of relationship to its full physiological influence; and that the best cures are often those made most quietly. Now, these principles being kept in view, I do not know that there is much to be added as to detail. Begin early; continue long; do not salivate—such would be my rules. I have no strong preference for one kind of mercurial preparation over another; but, as it is convenient to become familiar with one, I have in my own practice of late years almost restricted myself to gray powder. I prescribe it usually in pill, in doses from one to three grains three times a day, and often in combination with Dover's powder. It is only seldom that an unlooked-for salivation occurs, and it is equally rare to have any trouble with the bowels. Most of my patients continue throughout at their ordinary occupations. A strong reason for preferring to give pills, instead of using inunction or the bath, is, that it is often essential to avoid confinement to the house, and also to run no risk of attracting the attention of the family. Inunction, which is still in general use over the continent, and is without rival at Aix-la-Chapelle, is a more or less dirty method; can scarcely be concealed from servants; and further, with our English ointment, is very prone to irritate the skin and bring out eczema. As I do not believe that it has any real advantages to compensate for these drawbacks, I never resort to it. The vapour-bath, as proposed by Langston Parker and modified by Mr. Lee, I have the fullest faith in,

and have seen excellent results from it in certain intractable cases. It is, however, troublesome, more or less expensive, cannot well be used secretly, and, for all ordinary purposes, it is not in the least necessary. The gray powder does all that could possibly be wished. I must add to this, that I am always particular to use mercury sedulously to the local manifestations of the disease. The chancre is to be soaked with black wash; and to the skin-eruption an ointment of the ammonio-chloride is almost always applied. If the throat becomes sore, a gargle of black wash or of the bichloride is usually prescribed.

With regard to the dose, it ought to be sufficient to produce decided effect on the disease. If it be given for an indurated chancre, the hardness ought to begin to diminish within a week. The quantity required in order to effect this will be found, as every one knows, to vary very much in different individuals. A few patients will be met with who appear to resist mercury in a most extraordinary manner, in whom it neither destroys the syphilis nor affects the constitution. As a rough rule, I always expect to have to give more mercury to dark complexioned patients than to others.

Whether iodide of potassium is antidotal or not, it is very difficult to say; but I think we may take it as proved, that it is at best very feeble as an antagonist against the early stages of syphilis. It cannot make the indurated chancre disappear; and I think it does not usually shorten the duration of the secondary rash. A main object of my paper was to protest against its delusive employment in these stages, and to urge that it is false to our patients' interest to permit it to stand in competition with mercury, so far as they are concerned. Even in the case of the most feeble and cachectic patients, it is, I think, a mistake to resort to it, to the exclusion of mercury. But there is much respecting its powers which is yet to be made out. The rapidity and certainty with which it will cure some forms of tertiary disease are very wonderful; and from the inveteracy which these used to assume prior to its introduction, we may, I think, safely infer that the mercurial methods then in vogue were not successful. Of late years, mercury has been but very rarely tried for tertiary disease; and I for one may freely confess that I am not in possession of any large number of facts respecting it. Whether or not it might in certain cases cure more permanently than the iodide, I have no means of knowing; whilst that it would prove prejudicial in many is, I think, highly probable. Now, if the theory which I have advanced as regards the distinction between the secondary and tertiary maladies be true—that the former are due to blood-changes, and the latter to those of tissue—it possibly follows that we ought not to expect anything of the nature of prevention from the remedies which we use against the latter. It is enough if they cause the local inflammation to cease, and not possible that they should alter the constitution of the solid tissues, built up as they have been years ago, from a tainted blood. My impression is, that this conjectural view is supported by clinical experience, and that we do not find any benefit from continuing the iodide after the local cure has been completed.

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Silicate of Soda in Venereal Affections.—Sée (*Annales de Dermatologie et de Syphiligraphie*, 4me année, 1872-3) used a solution of silicate of soda, varying between one and three per cent of the salt in water, as an injection for urethral discharges or lotion for chancres, with or without phimosis. He experimented on twenty-five patients, and found that ill effects, orchitis, cystitis, bubo, etc., followed in none, however acute the stage of the disease; while, as a rule, the disorder was greatly shortened in duration, and in some was cured in a few days. Also, when used as a three per cent. lotion to phagedenic sores, it produced speedy improvement in their appearance; and in a case of chronic cystitis from lithic acid irritation, six injections cured the disease.—*London Medical Record*, Dec. 24, 1873.

Local Anæsthesia at Point of Insertion of Aspirator.—Dr. B. W. RICHARDSON calls attention (*Lancet*, April 4, 1874) to a little practical point of value when ether spray is used for preventing the pain caused by the puncture of the needle. It is this: after freezing thoroughly over the space of a crown-piece, at the point where the puncture is to be made, place the point of the finger in the centre of the frozen part, and thaw at that point completely. When the skin at the spot under the finger is thus rendered quite yielding, the needle can be passed through it still painlessly, if the surrounding part be kept thoroughly frozen. Dr. R. acknowledges his indebtedness to Mr. W. Adams for this suggestion.

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The Propagation of Cholera.—The official report of Dr. HIRSCH, just published by the German Government, on the appearance and march of the cholera in the Prussian provinces of Posen and Prussia in 1873, supports the conclusions established by British and Indian observers, that the cholera is carried along the lines of human communication. The experience of late years has proved that the disease is imported almost regularly by the barks on the Vistula, the wood-rafts, and the cargoes of wheat. The author shows by a series of carefully investigated facts, that the cholera advanced into Posen and Prussia along the course which the wood-trains pursue, and followed in their track. He dwells upon the necessity of public hygiene.—*London Medical Record*, April 1, 1874.

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Additional Method for removing Fibroids of the Uterus.—P. WALLIS (*Dorpater Medizinische Zeitschrift*, vol. iv. 1873) states that in two cases where he failed to remove the growths by the usual methods, he succeeded admirably by means of his hand, tearing through the attachments. Both cases did exceedingly well. The tumour in the one case was about the size of a man's fist; in the other a small soft fibroid.—*London Med. Record*, April 15, 1874.

Cells in Ovarian Fluid.—Dr. W. MACEWEN and Dr. R. FORREST, at a late meeting of the Glasgow Pathological and Clinical Society (*Brit. Med. Journ.*, March 28, 1874), showed specimens of ovarian fluid, and the former showed the microscopic cells supposed by Dr. Drysdale (Philadelphia) to be characteristic of ovarian tumors. Dr. Alex. Robertson and Dr. Joseph Coats said they had submitted these cells to careful examination, and to the test with ether, but had failed to verify Dr. Drysdale's statements on this subject.

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Death from a poisonous dose of Hydrate of Chloral.—An inquest has lately been held at Lincoln in England on the body of a woman, aged thirty-eight, who died from an overdose of hydrate of chloral. It appeared that she had been for some time past in the habit of taking various narcotics, and latterly had become a slave to chloral-drinking, which she took frequently and in large doses, as much as eighty grains at a time.—*Lancet*, April 11, 1874.

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Death of an Infant from using an Acetate of Lead Lotion to the Nipples.—M. BOUCHUT (*Gazette des Hôpitaux*, 1873) mentions a case where a lady had used a lotion called "Eau de Mad. Delacour," a favourite quack remedy in Paris for sore nipples. She had omitted to wash the lotion off before putting the child to the breast. It was seized with violent colic, and died in a few days with all the usual symptoms of lead poisoning.—*London Med. Record*, April 15, 1874.

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The Writing of Ataxic Patients.—At a recent meeting of the Biological Society of Paris, M. ONIMUS showed specimens of the handwriting of ataxic patients. They write in the same way as they walk, their writing presenting the characteristic irregularity and jerky abruptness. The letters are not rounded, the a's and o's being nothing but straight lines; whilst others have undefined terminations, such as the q's and the p's. At a more advanced stage, just as the foot strikes the ground

with violence, so the pen leans so heavily on the paper as to perforate it. Therefore, ataxic patients only use pencils.—*London Med. Record*, April 15, 1874.

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Contamination of Aerated Waters.—An eminent Fellow of the Royal Society communicates the following to the *British Medical Journal* (Feb. 14, 1874). Suspecting that lead might exist in potash-water contained in the ordinary siphon-bottles now generally in use, I placed six such bottles in the hands of Mr. Brownen, the expert chemist working in the laboratory of Messrs. Savory and Moore of Bond Street. I send herewith his report, and also results obtained from the examination of soda and of seltzer water contained in siphon-bottles.

It is highly important that this source of poisoning by lead should be made known, not only to the profession, but to the public.

Mr. Brownen presents the following report:—

Six siphon-bottles of potass-water, one of soda, and one of seltzer, were examined. All the samples contained lead. In two instances this metal was associated with zinc. The latter metal was identified by the white colour of its sulphide, its solubility with alkalies, and precipitation with potassium ferrocyanide. The proportion of lead in these bottles of water varied greatly, but in no case could it be estimated gravimetrically. The proportions were therefore estimated colourmetrically by comparison with a standard lead solution containing .1 of a *gramme* per *litre*, and precipitated by hydrogen sulphide from an acidified solution.

The following are the results obtained; the quantities stated being the amount of lead in a *litre*. No. 1 potassa-water, .012 *gramme;* No 2 ditto, .011 *gramme;* No. 3 ditto, .013 *gramme;* No. 4 ditto, .006 *gramme;* No. 5 ditto, .007 *gramme;* No. 6 ditto, .010 *gramme;* soda water, .0081 *gramme;* seltzer water, .012 *gramme.* As even carbonate of lead is somewhat soluble in carbonic acid water under pressure, it does not preserve the bottle, pewter cock, or luting from the well-known solvent action of alkaline salts on lead or zinc.

Retirement of Professor Hyrtl.—Dr. Hyrtl, the eminent Professor of Anatomy in the University of Vienna, delivered his final lecture on the 16th of March, and took leave of his class. In the afternoon, he met an assemblage of more than three thousand pupils and friends, who presented him with addresses and other expressions of esteem, which were feelingly acknowledged by him. During the day, more than fifty congratulatory telegrams were received from all parts of the world—Petersburg, Moscow, Paris, Philadelphia, London, New York, Constantinople, Berlin, Prague, Pesth, Cracow, and various other places in the Austro-Hungarian Empire, including Eisenstadt, Hyrtl's birthplace. The festivities of the occasion were prolonged to near midnight. On the following day, the Municipal Council of Vienna conferred honorary citizenship on him.—*Brit. Med. Journ.*, March 28, 1874.

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Proposed Statue of the late Dr. Robert J. Graves.—We take pleasure in calling attention to the subjoined circular, which has been sent to us, with the object, we presume, of inviting contributions for a statue of one who is well known in this country by his valuable contributions to clinical medicine, and who was one of the most eminent practitioners of his day.

Dublin, Merrion Square North,
December, 1873.

Dear Sir: A number of the friends, former pupils, and admirers of the late Dr. Robert J. Graves, residing in different parts of the kingdom, have agreed to form a committee for the purpose of receiving subscriptions for a statue, which, in accordance with a resolution of the College of Physicians, is to be placed in the hall of the College.

On behalf of the Committee we hope for your cordial co-operation and support in the endeavour to raise so well-deserved a memorial to this distinguished representative of the Irish School of Medicine.

Signed for the Committee.

William Stokes, A. Hudson, W. E. Wilde,

Hon. Secretaries.

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